2025

Children's Services Administration Trauma Protocol

MICHIGAN DEPARTMENT OF HEALTH & HUMAN SERVICES

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CHILDREN'S SERVICES ADMINISTRATION TRAUMA PROTOCOL May 2025

Table of Contents

INTRODUCTION

The information included in this Protocol is designed to outline the trauma screening and response process for all youth entering foster care in the state of Michigan. Additional resources, including focus on secondary trauma, and best practice guidance for ensuring that engagement with families is done in a trauma-informed way that helps support healing and builds resiliency is also included.

VISION

Michigan Department of Health and Human Services (MDHHS) Children's Services Administration is dedicated to ensuring that all public and private child welfare staff are equipped to:

1. Identify children who have experienced trauma; understand and engage with families about the impact of childhood trauma on their child's growth, emotions, and behavior.
2. Effectively respond to children impacted by trauma to help them cope, heal, and build resiliency.
3. Prevent re-traumatization for children and families they serve.
4. Use effective tools, strategies, and resources to advocate for the best interests of the children being served.
5. Build relationships and collaborate with caregivers and community service providers/organizations to support the education of and development of a trauma-informed community.
6. Recognize the impact of secondary trauma on staff and implement a safe, supportive, trauma-informed office culture and climate.

With these goals in mind, Michigan child welfare leadership and staff are committed to implementing and supporting the use of trauma screening/rescreening, engagement of families and service providers, effective case planning focused on building resiliency, and addressing secondary trauma.

ADMINISTRATION OF TRAUMA SCREENING CHECKLIST

Staff must utilize the appropriate MDHHS Trauma Screening Checklist (MDHHS -5719/MDHHS-5720) based on the age of the child, 0-5 or 6-18 years of age. Administration of the Adult Trauma Screening Checklist, or other adult focused Trauma Screening tool, may be used optionally for engagement and case planning purposes for young adults over age 18, or for parents, as the worker deems appropriate. Because formal guidance is not available for screening results for individuals over age 18, prior consideration should be given to local resources that could be beneficial, and how the information may inform case service planning.

Caseworkers are required to administer the Trauma Screening Checklist to each child victim involved in an ongoing CPS or foster care case within 30 days of case opening and according to the *MDHHS Trauma Screening Checklist Instruction Guide*. **Screening during an active CPS investigation is optional** to assist with engagement and determine what services may be beneficial for the child and/or family regardless of case disposition. A referral for a Comprehensive Trauma Assessment should not be made by CPS if the case is disposed as a category III, IV, or V. In instances when a child in a category III, IV, or V CPS case scores an 11+ on the Trauma Screening Checklist, the child/family should be provided resources for behavioral health services to address the trauma.

Exceptions to the timeframe for administration of the Trauma Screening Checklist may be granted at the discretion of the supervisor and documented in MiSACWIS. A Comprehensive Trauma Assessment cannot be completed for youth whose case is closed prior to completion of the Comprehensive Trauma Assessment regardless of whether a referral has been made. Therefore, caseworkers and supervisors should use discretion when making a referral for a Comprehensive Trauma Assessment if case closure is anticipated to occur prior the time that the assessment could be completed.

Completed Trauma Screening Checklists should be uploaded into MiSACWIS, Person Profile, labeled *Trauma Screening Checklist*, followed by the date it was administered.

RESCREENING

Rescreening is a crucial activity to help assess 1) how a child's symptoms/behaviors have changed, 2) if resiliency has been built, and 3) what services have/have not been beneficial. At least one rescreening is required to be completed within 180 days of the initial screening, and prior to case closure. Results must be documented in MiSACWIS, including identified changes from the initial screening. Additional screenings should be considered prior to or immediately following significant changes within the child's life (placement change, goal change, etc.) and can be completed with supervisory discretion to assist with further assessment or case planning as needed throughout the case.

RESPONSE TO TRAUMA SCREENING RESULTS & THRESHOLDS FOR REFERRAL

Caseworkers should document the administration and results of each trauma screening and rescreening in MiSACWIS, including:

- Date the interview was conducted with the child AND date the Trauma Screening Checklist was completed
- Name of person screened
- Results of the Trauma Screening Checklist (total score/endorsements)
- Changes from initial/previous Trauma Screening Checklist, if applicable
- Plan to address screening results

Caseworkers should refer to the *Trauma-Informed Care: Best Practices Guide*, located at the end of this document, for how to incorporate resiliency-based case planning strategies into the child's case service plan.

Referral for a Mental Health Assessment/treatment and/or a Comprehensive Trauma Assessment are not intended as standard practice for every child, and should be based on the following:

TOTAL SCORE (Endorsements) on Trauma Screening Checklist	**Recommended Action**
0-3	**No referral required** based only on results of the Trauma Screening Checklist. Determine appropriate next steps for case planning on an individual basis.
4-5	**Make a referral for the child to be assessed for mental health services.** For children receiving Medicaid, refer to local Community Mental Health (CMH) or Medicaid Health Plan (MHP) behavioral health providers.

6-10	***Convene a team**** to discuss current services the child may be receiving, including mental health services. If the child is not making progress in current treatment goals as identified by child/caregivers, consider making a referral to the child's current therapist or local CMH provider for a **Mental Health Assessment** (as described below) that incorporates trauma exposure and impact.
11+	***Convene a team**** to discuss current services the child may be receiving, including mental health services. If the child is not making progress in services, consider making a referral for an assessment and determine appropriate type of assessment (described below): **Mental Health or Comprehensive Trauma**. Section 1 on the Trauma Screening Checklist must have at least one trauma exposure identified to refer for a Comprehensive Trauma Assessment.

NOTIFICATION TO CURRENT PROVIDERS

Regardless of the score on the Trauma Screening Checklist, caseworkers should share results of the screening/rescreening with current health/service providers as soon as possible, but no later than the following scheduled Family Team Meeting (FTM) and determine if additional discussion or planning is necessary.

*CONVENING A TEAM/TEAM DISCUSSION

When indicated based on trauma screening results, convene a Family Team Meeting (FTM) or Wrap Around meeting. Team members should include MDHHS/Private Agency caseworker, parents, family member(s), caregiver(s), CMH or current mental health provider (if involved), school personnel (if applicable), other providers and support persons identified by the parents (relatives, faith-based support persons, etc.). Ensure the appropriate release of information has been completed for all participating team members. Discuss and consider the child's needs, including progress in services, if and how current behaviors and trauma history are being addressed, current placement stability and functioning at home, school, with peers, and in the community. Incorporate the recommendations of the team into the child's case service plan and make additional service referrals or link to additional community resources/supports as needed.

EXCEPTION PROCESS FOR ASSESSMENTS

If a completed Trauma Screening Checklist does not reach a score that the worker believes is indicative of an appropriate intervention as outlined above, the worker should consult with their supervisor, and the child's team, if necessary, to determine if an escalation of intervention is appropriate. Supervisory approval is required if a referral for an assessment that is not consistent with the thresholds outlined in the table above is being made.

PRIORITY POPULATION

When residential placement is being considered due to disrupted community placements, behavioral concerns, or unsuccessful interventions, caseworkers should immediately conduct a trauma screening and consult with their supervisor to determine if a referral for a Comprehensive Trauma Assessment is needed. Recommendations from the assessment should be implemented to build a treatment plan that focuses on keeping the child within the community. If the child cannot be placed within the community and is placed in a residential facility based on assessment by MDHHS's contracted entity to determine

appropriateness of residential placement, the recommendations from the trauma assessment must be shared with the QRTP IA team and facility for implementation.

CONSIDERATIONS AND REFERRALS FOR CHILDREN LESS THAN 3 YEARS OLD

Prior to out-of-home placement of a child less than three years of age, workers should obtain commitment of the prospective foster parent(s) or relative(s) to be involved in Early On, required medical appointments/immunizations, Infant/Early Childhood Mental Health services, or other services determined appropriate to serve the best interests of the child.

Prior to referral for a Comprehensive Trauma Assessment, any child **less than three years of age** must have been referred to ALL the following providers:

- Medical Professional/Pediatrician
- Early On
- CMH for Infant/Early Childhood Mental Health treatment services

For children less than three years of age, at least one of the professionals listed above must recommend that a referral for a Comprehensive Trauma Assessment is needed. Documentation of the decision to refer, including applicable reports, must be included with the *Trauma Assessment Referral/Invoice* (MDHHS-5594). If there is not consensus among the team regarding referral, the final determination for referral must be made by the caseworker, with the approval of the supervisor and subsequently communicated with the child's team.

TYPES OF ASSESSMENTS

***Mental Health Assessments*:** If a Mental Health Assessment is recommended, inquire if the child's current provider can complete the assessment. If not, proceed with a referral to the local CMH. Mental Health Assessments are not covered under a contract. A Mental Health Assessment consists of a comprehensive biopsychosocial assessment, including the exposure to and impact of trauma(s) experienced by the child. A trauma specific assessment may be included (i.e., UCLA, TSCYC), as well as other assessment tools/instruments appropriate for the child that describe the symptoms/difficulties experienced by the child, identifies strengths and needs, and determines a mental health diagnosis. Once the Mental Health Assessment is completed, review the recommendations.

- If there are no recommendations for mental health treatment:
    - Notify primary care physician for further follow-up,
    - Follow the ongoing case service plan, and
    - Rescreen as required or if new information indicates a need.

- If there are recommendations for mental health treatment to address emotional or behavioral concerns, whether or not these are related to trauma exposure:
    - Begin treatment
        - Continue case service plan if child responds to treatment.
        - If the child does not participate in treatment or is not responding to treatment in a reasonable timeframe, as determined by the team: time:
            - Consult with the therapist, and
            - Schedule a Family Team Meeting, including appropriate service providers and support persons, to determine next steps.

***Comprehensive Trauma Assessments*:** A Comprehensive Trauma Assessment is a contracted service that is more extensive than a Mental Health Assessment and is specifically for children who suffer significant trauma that is having a dramatic adverse impact on behavior, judgement, educational performance, and/or the ability to connect with caregivers. This assessment should not be used for children who are currently benefitting from existing services. In addition to 11+ endorsements identified on the Trauma Screening Checklist, signs that a Comprehensive Trauma Assessment may be appropriate include:

- Not benefiting from current services – referrals for services based on the child's identified needs should be explored prior to referring for a Comprehensive Trauma Assessment.
- Academic failure in at least one area and/or difficulty functioning in school setting – **frequent** discipline issues.
- Concerning and/or major mood and behavior present in **more than one** environment – stability in school or home placement may be at risk.
- Treatment for disorders appears under or ineffective – stability in school or home placement may be at risk.
- Concerns related to speech/language, motor, sensory or developmental milestones (i.e., are they acting similar to other children their age).

A Comprehensive Trauma Assessment is available for children with an ongoing category I or II CPS case, an active foster care or juvenile justice case, or children in an adoptive home when a referral is made by a Post Adoption Resource Center (PARC). Referrals MUST be made to a provider who is contracted by MDHHS to conduct a Comprehensive Trauma Assessment and should be made to contractors in that county's service area unless an exception is made by the county director and documented with rationale on the MDHHS-5594. A Comprehensive Trauma Assessment report should:

- Include recommendations for treatment, services, and clinical and non-clinical interventions and strategies to assist the child, the child's family, and caregivers. *For example, recommendations may address the need for individual or family therapy, medication management, further clinical testing, specific trauma informed modalities or interventions, and strategies for the parent/caregiver to effectively manage challenging behaviors and build resiliency.*
- Provide information about the child's condition and needs that will help inform casework decisions. *For example, the report may highlight a child's sensitivity to loud noises and chaotic environments and recommend a calm, quiet setting when arranging parenting time. The report may highlight the impact of repeated loss on the child and recommend that the child's overriding need for stability be strongly considered when making placement decisions. It would not be appropriate for the Trauma Assessment to include a specific recommendation for a legal permanency goal, for a specific placement setting, or for whether parenting time should occur. These are decisions that are guided by law, policy, and a holistic view of case facts, including social, clinical, and legal information.*

ELIGIBILITY CRITERIA

To be considered for a comprehensive trauma assessment, a child must meet the following eligibility requirements:

- The child has a current open Michigan Department of Health and Human Services (MDHHS) foster care, child protective services (CPS), or MDHHS juvenile justice case. The current open MDHHS foster care, CPS, or juvenile justice case must remain open until the comprehensive trauma assessment report is

completed and sent to the case manager. The recommendations must be reviewed with the family, plans must be made for implementation of the recommendations, and the invoice must be paid.
    - Note: CPS cases must be open as a category I or category II to be eligible for comprehensive trauma assessments. CPS investigations, category III, category IV, category V, and prevention cases are not eligible for comprehensive trauma assessments.
- The child must be age 0-17.
    - Prior to referral any child less than three years of age must have been referred to all of the following:
        - Medical professional/pediatrician.
        - Early On.
        - Community Mental Health for infant/early childhood mental health treatment services.
    - Note: At least one of the professionals listed above must recommend a referral for a comprehensive trauma assessment. Documentation of the decision to refer, including applicable reports, must be included with the MDHHS-5594, Trauma Assessment Referral.

The child must also meet one or more of the eligibility criteria below:

- The child is struggling with functioning and behaviors in their current placement despite participating in services.
- The child entered care within the last 30 calendar days, and current placement is in danger of disrupting due to the child's functioning and behaviors. Child has not been referred to or started services.
- The assessment is recommended by a current mental health clinician or current medical professional.
- The child is not benefiting from current services AND received an 11+ on the trauma screening checklist.
- The assessment is court ordered.

REFERRAL PROCESS FOR COMPREHENSIVE TRAUMA ASSESSMENTS

Policy for Comprehensive Trauma Assessments can be found in FOM 802, *Mental Health, Behavioral and Developmental Needs of children Under the Supervision of MDHHS.* The Comprehensive Trauma Assessment Job Aid can be located Comprehensive Trauma Assessment Job Aid.pdf (michigan.gov).

A referral for a Comprehensive Trauma Assessment must not be made by CPS if the case is disposed as a category III, IV, V or prevention. In instances when a child in a category III, IV, V, or prevention CPS case scores an 11+ on the Trauma Screening Checklist, the child/family should be provided resources for behavioral health services to address the trauma.

When it is determined that a child should be referred for a comprehensive trauma assessment, the caseworker must do the following:

1. Complete the MDHHS-5594, Trauma Assessment Referral/Invoice, and attach all supporting documentation.
   NOTE: The contractor cannot accept incomplete referrals per the contract. All sections of the referral form must be complete. Incomplete referrals will be rejected.
2. Submit the MDHHS-5594 and supporting documentation to supervision for approval. Once approved by supervision, the MDHHS-5594 and supporting documentation must be submitted to the county

director for final approval. The county director will assign a contractor to the referral based on the contractor rotation and county's region.

3. Enter a case service into MiSACWIS. Upload the MDHHS-5594 and supporting documentation into the document section of MiSACWIS and route the case service authorization to supervision for approval. Once approved, supervision must route the case service authorization to the behavioral health analyst with the Child Welfare Permanency and Wellbeing Unit for final approval.
   NOTE: The case service authorization must be approved by the behavioral health analyst prior to sending the referral packet to the assigned contractor.
4. Send the completed referral packet to the assigned contractor. The contractor must complete all related contract activities and send the completed report to the referring caseworker within 75 calendar days of the date the completed referral was sent to the contractor.

Counties that have more than one contractor for their area will assign to area contractors on a rotational basis. The county director/district manager/designee is responsible for tracking the rotation and referring to the appropriate provider. Any exceptions to the rotation must be documented in detail on the MDHHS-5594 by the county director. Reasons for exceptions include, but are not limited to:

- Child and other participants live outside the county and would be best served by a contractor closer to their home.
- Contractor provided an assessment for a sibling and is not next in rotation.
- Contractor next in rotation refuses the referral because of capacity or for some other reason.

COMPREHENSIVE TRAUMA ASSESSMENT REPORT

Following the assessment, the contractor must provide the caseworker an assessment report that includes components outlined in the contract, including:

- Individual and/or family interview summary
- Tests given, results and interpretation
- Client strengths and identified concerns
- Specific diagnoses, if clinical criteria are met
- Recommendations for follow up and treatment, including evidence-based treatment options and resources that are regionally accessible
- Strategies to assist the parent/caregiver with helping the child heal and build resiliency in the home/school/community

Although considerations for certain scenarios may be included, contracted trauma assessment reports should not include specific recommendations regarding permanency, placement, and parenting time. These best interest decisions are made by the caseworker based on a holistic review of the case, and in discussion with their supervisor.

PAYMENTS FOR COMPREHENSIVE TRAUMA ASSESSMENTS

The established rate for the contracted Comprehensive Trauma Assessment is $2343.33. Payments will need to be entered into MiSACWIS and the MDHHS-5594 should be uploaded into MiSACWIS. Contractors may be reimbursed for pre-approved ancillary services as outlined on the MDHHS-5599, *Ancillary Service Approval* form. Once the service is approved by the county director/designee, the MDHHS-5594 will be sent to the

service provider, including the MiSACWIS service authorization number. Once the assessment is completed, the contractor must complete the appropriate section of the MDHHS-5594 and send it, along with the report, to the caseworker. Following the receipt of the report, the caseworker must add the date the report was received as the completion date for payment from MiSACWIS to be issued to the contractor. The caseworker should also upload the Comprehensive Trauma Assessment report into MiSACWIS. Please see the appropriate Case Service Creation and Payment Job Aid for further instruction on entering these payments.

ADDITIONAL COMPREHENSIVE TRAUMA ASSESSMENTS

Comprehensive trauma assessments are intended to provide information that will inform ongoing case and treatment planning. Although specific elements of a child's situation may change, in nearly all circumstances an additional comprehensive trauma assessment is not necessary to incorporate new information into case and treatment planning. The changes that may prompt consideration of an additional trauma assessment are listed below are listed below.

Prior to requesting an additional comprehensive trauma assessment, all of the following must apply:

1. It has been a minimum of 2 years since the first comprehensive trauma assessment.
2. All recommended services and actions steps identified in the first comprehensive trauma assessment report have been implemented.
3. Current services and interventions are not having an impact on the child's behaviors and/or mental health needs.
4. There has been a significant traumatic event in the child's life.

NOTE: If the court orders an additional comprehensive trauma assessment, the court order must be attached to the comprehensive trauma assessment referral packet.

Information regarding the prior trauma assessment must be included on the MDHHS-5594 and the prior comprehensive trauma assessment must be included in the comprehensive trauma assessment packet.

CASE PLANNING FOLLOWING SCREENING AND ASSESSMENT

Based on results of the trauma screening and any subsequent assessment, appropriate trauma-specific treatment or trauma-informed services for the child and family must be included in the child's case service plan, as well as specific activities/strategies designed to help the child heal and build resiliency. Caseworkers should refer to the *Trauma Screening Best Practices Guide* at the end of this document for strategies to help build resiliency for the child and their family.

Caseworkers must also partner with available community service providers and utilize local resources to ensure these services are provided. Additionally, appropriate referral(s) for the parent/caregiver should also be made, which may include Resource Parent Training. Treatment interventions, including services and strategies used to help build resiliency, should be documented in MiSACWIS.

Best interest decisions, such as permanency, parenting time, and placement should be made by the caseworker, based on a holistic view of the child's case, and following supervisory discussion and support. Guidance regarding decision making in child protection can be found at: https://www.childwelfare.gov/topics/responding/child-protection/decision-making/.

SECONDARY TRAUMA

Each county office shall adopt and outline approaches that help prevent and address secondary traumatic stress for all child welfare staff, including, but not limited to:

- Creation of a value statement that recognizes staff and their well-being as paramount.
- Development of a written/formal protocol on the process for accessing help and support for staff who are experiencing secondary traumatic stress.
- Creation of a trauma-specific debriefing process for difficult cases or incidents.
- Integration of specific action steps developed to enhance office culture and climate.
- Discussion during supervision on the impact of the work on staff.
- Utilization of evidence-based management practices to promote a supportive office culture/climate, including ensuring the physical and psychological safety of staff and establishing ground rules to prevent workplace bullying.
- Training to help supervisors/managers recognize signs of secondary traumatic stress among staff.
- Mechanisms for sharing self-care and coping strategies.
- Other organizational support available (MDHHS employee service program, agency employee assistance program, secondary traumatic stress teams, etc.).

TRAUMA-INFORMED CARE: BEST PRACTICES GUIDE

PURPOSE:

The purpose of the information below is to provide examples of non-clinical strategies that can be implemented by workers to assist children and their families with building resiliency and healing from trauma. The worker is encouraged to use these strategies regardless of the score obtained on the Trauma Screening Checklist.

ENGAGING PROVIDERS/BUILDING RESILIENCY:

Always share the results of the Trauma Screening Checklist with the appropriate people, including the child's parent(s), caregiver(s), teacher(s), and other service providers, as long as an appropriate release of information is completed if the individuals do not have authority to review the documents under care coordination. Engage these individuals to discuss the child's treatment plan and progress; implement strategies for building resilience; determine what local resources may be beneficial and assist by making referrals to connect the child and their family to services, if necessary.

RESILIENCY-BASED CASE PLANNING:

Resiliency-based case planning is a critical part of helping children and families successfully heal from trauma. There are four key components of resiliency-based case planning: 1) Relatedness, 2) Mastery/Efficacy, 3) Affect Regulation, and 4) Self-esteem. Specific strategies, identified below, can be implemented by the worker and other providers or support people to help build resiliency.

Relatedness: How to promote the person's ability to develop and build relationships.

- Discover who the important people are in the person's life.
- Include important people in the plan by contacting them.
- Seek out family members.

- Seek out mentors/support people.
- Model genuine interest in and care for the child or adult.
- Communicate new information as honestly and truthfully as possible (build relational safety).
- Educate the caregiver at the child's placement to help them understand that the precursor for developing a relationship is making the child feel safe.
- Recognize and appreciate the impact of a parent's own history of trauma and how it may affect the relationships with the children.
- Engage the caregiver's participation in decision-making during periods of change or crises, but also in common child caring responsibilities such as medical and academic planning.
- Reframe the need for "attention" from caregivers as seeking relational connections.
- Appreciate and respect the child's inability to trust. For example, "I know it is really hard, or maybe even impossible, to trust me and that's OK. Trust takes time. The first thing I want to do is try to help you feel safe, both in your body and in your head."
- Tell the child you want to understand their perspective by saying something like, "please teach me about you," "tell me what you see" or "tell me how you feel." Children need to be understood before they can build relationships.

Mastery/Efficacy: How to promote the person's mastery/competency

- Identify areas of strengths.
- Create opportunities for the child or adult to use their strengths to experience success.
- Teach that frustration and/or failure is a component of developing competency.
- Support the child or adult in accessing opportunities to develop and utilize strengths.
- Support the child or adult's participation in activities that build efficacy even when the person is struggling with emotional and/or behavioral control.
- Recognize and validate successes.
- Do not threaten or take away experiences where the child is successful as a motivator to change their behavior. Motivation comes from success.

Affect Regulation: How to improve the person's ability to regulate emotion and behavior

- Help parents/caregivers model emotional identification and expression.
- Educate parents/caregivers on brain-based behavior that is survival-driven. Help them understand that children are 'doing the best they can' and communicate it effectively. Avoid triggering language such as, "You just need to try harder."
- Teach parents/caregivers how to help the child identify and label emotions.
- Model and encourage the practice of calming strategies for the child to learn to manage emotions.
- Do not react to the child's behavior/emotion, but rather embrace emotional expression as progress toward regulation and recovery.
- Implement safety plans that recognize how traumatic experiences have affected a child's reactions to people, places, and experiences. Pay particular attention to times that the child struggles to self-regulate, according to the environment and context they are in. This will help identify the child's primary triggers.

- Use caution when interpreting a child's reaction before, during and after parenting time. Develop a safety plan that engages parents/caregivers, providing structure and safety during transitions and periods of separation.
- Model physical activities, such as controlled breathing, and practice with the child to help them experience calming.

Self-esteem: How to improve the way in which a person perceives himself/herself.

- Practice giving specific praise; encourage and model for caregivers/parents to practice it as well.
- Catch the child doing something good.
- Remind the child of their positive qualities.
- Utilize a non-judgmental focus. Remind self and parents/caregivers that undesirable behavior may reflect survival strategies and does not define the child's character.
- Honor the child's relationships with biological family. Discuss their parents' need for help in an age-appropriate, non-judgmental, and honest manner.
- Create opportunities to be successful.

TIPS FOR PARENTS, CAREGIVERS and SERVICE PROVIDERS:

When working with parents, caregivers, teachers, and other providers, educate them and share tips/strategies for addressing trauma, which may include:

- **Provide safety** by making sure the child feels safe and has a sense of control within their environment. For example, let children who have experienced trauma sit in the back of the classroom (allowing them to see everyone and be aware of their environment).
- **Remain calm** when a child presents with acting out behaviors. Do not shame or blame.
- Use positive reinforcement. For example, reward a child for doing well; do not take away something that provides a sense of security or mastery.
- **Maintain items, relationships and activities** that are important to the child and their sense of self.
- **CONNECTION before CORRECTION.** Engage with the child so he/she knows you care about him/her before attempting to correct behavior.
- When a child is anxious: **Stay calm, be quiet, slow down, be observant.**

TRAUMA RESOURCES

The following links provide additional information and resources regarding trauma, including: the types and impact of trauma, tools to address trauma, building trauma-informed systems and communities and resources for parents/caregivers and providers:

- **MDHHS Trauma and Toxic Stress**
- **MDHHS Child Welfare Medical and Behavioral Health Resources:**
- **National Child Traumatic Stress Network (NCTSN)**
  - Types of Trauma
  - Child Adult Relationship Enhancement
  - Secondary Trauma: Taking Care of Yourself Tool
  - Family, Youth, Provider Partnership: Sharing Power Tool
- **Secondary Traumatic Stress & Culture/Climate Toolkit**